Learner Support Document for:
Assessment Strategies for Manual Therapists Seeking Somatic Harmony and Osseofascial Balance For Chronic Pain PatientsWelcome

Sample Patient Information/Informed Consent Form

This information is provided to help you understand the treatment I am recommending for you. Before I begin treatment, I want to be certain that I have provided you with enough information in a way you can understand, so that you're well informed and confident that you wish to proceed. This form will provide some of the information. I will also have a discussion with you.

PLEASE BE SURE TO ASK ANY QUESTIONS YOU WISH. It's better to ask them now, than wonder about it after we start the treatment.

Nature of the Recommended Treatment:

I am recommending the following treatment(s) for you:
_____
I base this recommendation on the visual examination(s) I have performed, on any x-rays, models, photos and other diagnostic tests I have taken, and on my knowledge of your medical and dental history. I have also taken into consideration any information you have given me about your needs and wants. The treatment is necessary because:
_____

The benefits of this treatment are: _____
_____
The prognosis, or chance of success, of the treatment is:_____

I expect that it will take approximately _____to complete the treatment, but it could be shorter or longer based on what we experience as the treatment progresses. I expect it to cost about €_____and I will let you know as soon as possible if the cost estimate increases or if it can be reduced.

Alternative Treatments:

There are many ways to treat pain problems. I have chosen the one that I think best suits your needs. However, there are other ways that your condition can be treated, including:
_____
If you have any questions about these alternatives, or about any other treatments you have heard or thought about, please ask.

Risks Of The Recommended Treatment

No manual therapy treatment is completely risk free. I will take reasonable steps to limit any complications of the treatment I have recommended. However, there are some complications that tend to occur with some regularity. These can include post-treatment soft-tissue tenderness and:
_____

If you have any questions about these complications, or about any other complications you have heard or thought about, please ask. I believe that the treatment will be most successful when you understand as much as possible about it, because you will be able to provide more information to me and to ask better questions. No question should be avoided or thought of as not good enough and I have as much time to answer them as you need. When you feel you can make on educated decision about this recommendation, then we can get started with treatment.

Acknowledgment

I_____, have received information about the proposed treatment. I have discussed my treatment with NAME OF THERAPIST._____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

I wish to proceed with the recommend treatment.

Signed (Patient):_____

Date:_____

Patient or Guardian (If required)
Signed:_____

Date:_____

Treating Health Care Therapist
Signed:_____

Date:_____

Witness (If required)
Signed*:* _____

Date:_____

You may wish to include details about your professional credentials,if you accept payment via insurance cover or not, details and permissions if you record the session, confidentiality, e-mail notifications, cancelation policy and more.

General Manual Therapy Informed Consent Form

1. Treatment Plan

I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent form I am in no way obligated to any treatment. I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found or changes in the conditions, while working on the tissues, that were not discovered during examination or are as a consequence of the treatment.

Drug and Medications

I understand that medications such as antibiotics, analgesics, blood thinners, etc can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock and I have informed the therapists of all medications I am taking and any allergies that I am aware of concerning foods, oils, creams, wax or other.

I understand that manual therapy is not an exact science and that, therefore, reputable practitioners cannot empathically guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the manual therapy treatment, which I have requested and authorized.

Patient_____ Date_____

Therapist_____ Date_____

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr._____ and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature of patient, legal guardian, or authorized agent of patient:

Date:

DENTAL SERVICES
CONSENT FOR SURGERY

Patient Name_____Date of Birth_____
I hereby authorize Dr._____, and any other dentists of _____ to perform the following treatment or surgical procedure_____, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
2. Resticted mouth opening for several days or weeks.
3. Prolonged bleeding.
4. Nausea and vomiting (usually associated with medications prescribed for pain).
5. Postoperative infection requiring additional treatment.
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
7. Damage to adjacent teeth, fillings, and crowns.
8. Stretching of the corners of the mouth with resulting cracking and bruising.
9. Opening into the maxillary nasal sinus or nose requiring additional surgery.
10. Prolonged drowsiness.
11. Change in occlusion and temporal-mandibular joint difficulty.
12. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent.
13. Fracture of the jaw.

( ) I consent to the administration of **local anesthesia (Novacaine), nitrous oxide analgesia** or **oral sedation** in connection to the procedure referred to above (circle all that apply).

I certify that I have read the above and fully understand this consent for surgery, and that I understand that a perfect result cannot be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. If instructed to do so, I will not drive or perform hazardous chores until I have recovered from the effects of these medications.

_____ _____
Patient's Signature Date

_____ _____
Parent or Legal Guardian (if patient under 18 yrs of age) Date

_____ _____
Witness or Interpreter Date

_____ _____
Dentist's Signature Date

DENTAL PROGRAMS
CONSENT FOR ENDODONTIC (ROOT CANAL) SERVICES

Patient Name_____Date of Birth_____
I hereby authorize Dr. _____, and any other dentists of _____ to perform an endodontic (root canal) procedure on tooth (teeth) _#_____, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Root canal therapy is indicated when the pulp chamber of a tooth is contaminated by bacteria causing the canals to become infected. The procedure is accomplished when the dentist creates a small opening in the biting surface of the tooth that will allow it to be disinfected and then sealed with an inert rubber-like substance. The sealing of the canals prevents subsequent passage of bacteria into or out of the tooth.

I have been informed that the risks to my health if this procedure is not performed may include, but are not limited to: increased pain, swelling, loss of the tooth (teeth), loss of other teeth nearby, loss of the supporting bone, spreading infection, cyst formation, and/or deterioration of general health due to systemic infection.

I have been informed of possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

- A failure to completely eliminate the infection requiring retreatment, root surgery or removal of the tooth at a later date;
- Post-operative pain, swelling, bruising, and/or limited jaw opening that may persist for several days;
- Separation (breakage) of an instrument within the canal during treatment. Broken instrument tips are typically allowed to remain in the canal, and only rarely are they the cause of subsequent problems. If removal is indicated the patient may be referred to an endodontic specialist.
- Perforation of the root from within the canal can occur requiring additional treatment by a specialist. Such complications will occasionally result in the loss of the tooth.
- Damage to nerves supplying the teeth resulting in temporary or, in rare instances, permanent numbness or tingling of the lip, chin, or other areas of the jaws or face:
- Inability to adequately clean the canal(s) due to unforeseen calcified obstructions or severely bent roots. Under certain circumstances the patient may be referred to a specialist for successful completion of the procedure. Loss of the tooth may occur:
- A fracture of the treated tooth, occuring during or after endodontic treatment. Treated teeth sometimes break due to the tooth's loss of strength resulting from the procedure. In most cases a crown is recommended after treatment to prevent such an occurrence.

Once treatment has begun, it is essential that it be completed in a timely manner. Root canal treatment will require from 1-5 appointments. Also, I understand that successful treatment does not prevent future decay or fracture of the treated tooth.

I understand the recommended treatment, the risks of such treatment, alternative treatments should any exist, and the consequences of doing nothing.

Patient's Signature_____ Date_____

Parent or Legal Guardian Signature_____ Date_____

Witness or Interpreter_____ Date_____

Dentist's Signature_____ Date_____